BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

RONALD A. TRIPOLI	)	
Claimant	)	
VS.	)	
	)	
VATTEROTT EDUCATION HOLDINGS, INC.	)	Docket No. 1,059,113
Respondent	)	
AND	)	
	)	
ACCIDENT FUND INSURANCE COMPANY	)	
Insurance Carrier	)	

ORDER

Claimant appealed the February 14, 2014, Award entered by Administrative Law Judge (ALJ) Gary K. Jones. The Board heard oral argument on June 18, 2014, in Wichita, Kansas.

APPEARANCES

Terry J. Torline of Wichita, Kansas, appeared for claimant. Matthew J. Schaefer of Wichita, Kansas, appeared for respondent and its insurance carrier (respondent).

RECORD AND STIPULATIONS

The record considered by the Board and the parties' stipulations are listed in the Award. At oral argument, the parties were asked to stipulate that the Board could consult the *Guides*[1] when making its findings, but respondent declined. Therefore, the Board will only consider those provisions of the *Guides* placed into evidence.[2]

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[1] American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

[2] See *Durham v. Cessna Aircraft Co.*, 24 Kan. App. 2d 334, 945 P.2d 8, *rev. denied* 263 Kan. 885 (1997).

ISSUES

ALJ Jones found claimant sustained a personal injury by accident arising out of and in the course of his employment with respondent on December 3, 2011. The ALJ determined claimant sustained a 7% whole body functional impairment. Because claimant's whole body functional impairment was not greater than 7.5%, claimant was not entitled to benefits for a work disability.[3] The ALJ awarded claimant future medical benefits upon proper application to and approval by the Director of the Division of Workers Compensation.

Claimant asserts the ALJ's decision to award him a 7% whole body functional impairment is not based upon any evidence in the record, nor is it based upon the *Guides*. Claimant contends the ALJ erroneously penalized claimant for Dr. C. Reiff Brown's actions during his deposition. At oral argument, claimant requested the Board find he sustained a whole body functional impairment of 10% based upon Dr. Brown's opinions.

In the alternative, claimant requested the Board give equal weight to the opinions of Drs. Brown and Mark S. Dobyns and find claimant has a 7.5% whole person functional impairment rating. Claimant asserts the *Guides* calls for a fractional functional impairment rating to be rounded to the nearest whole number. Therefore, claimant's 7.5% functional impairment should be rounded up to 8%, which qualifies claimant for a work disability.

Respondent objects to the admissibility of Dr. Brown's deposition transcript and exhibits thereto. After being cross-examined at length, Dr. Brown abruptly refused to answer any more questions. Respondent contends claimant did not sustain a personal injury. If the claim is compensable, respondent maintains claimant sustained a 5% whole body functional impairment as opined by the treating physician. Respondent asserts claimant's request for work disability benefits should be denied as his functional impairment does not satisfy the threshold requirement to qualify for work disability benefits and his current wage loss is not due to his work injury. If claimant qualifies for a work disability, respondent contends he sustained a 21.53% work disability. Respondent maintains claimant does not require future medical treatment.

The issues before the Board on this appeal are:

1. Should Dr. Brown's deposition transcript and exhibits thereto be stricken from the record?

2. Did claimant sustain personal injury by accident arising out of and in the course of his employment with respondent?

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[3] See K.S.A. 2011 Supp. 44-510e(a)(2)(C)(i).

3. What is the nature and extent of claimant's disability?

4. Is claimant entitled to future medical benefits?

FINDINGS OF FACT

After reviewing the entire record and considering the parties' arguments, the Board finds:

Claimant was Director of Admissions for respondent. On December 3, 2011, a Saturday, he was cleaning out a storage room, as directed by his supervisor, Mike Harris. While stretching to get something off the top shelf, claimant's foot slipped and he fell on the ceramic tile floor. Claimant testified his back, buttocks, and where his neck meets his back hit the floor, as well as the back of his head. Pieces of banding that wrap around boxes and partial pieces of cardboard were on the floor. Only claimant was present at the incident. After his fall, claimant continued cleaning the storage room.

Claimant testified that three days after he reported the work accident, he was discharged by respondent. At the time of his deposition, claimant was receiving unemployment benefits and anticipated receiving them for two more weeks. Claimant indicated that prior to being discharged, he was written up at work for not being a team player and making typographical errors on materials sent by email.

Respondent asserts claimant lacks credibility because his deposition testimony on several matters changed at the regular hearing. At his deposition, claimant testified of having no convictions for crimes involving dishonesty. He later corrected this on his deposition correction sheet by indicating he had been convicted of such a crime approximately 32 years earlier. He testified he injured his left shoulder when his motorcycle fell on him while he was trying to push start it "probably somewhere in the spring"[4] of 2011. Claimant also testified he had no issues with his low back prior to the work accident. Claimant indicated that at respondent he received general department write-ups and write-ups specific to him.

At the regular hearing, claimant gave a similar description of his work accident as he did at his deposition. Claimant again testified he was terminated three days after he reported his work accident. He indicated he was terminated for sending out emails with inappropriate language or typographical errors and that he used the wrong terminology in an email. Claimant applied for, and received, unemployment benefits. He testified he continually looked for work while receiving unemployment benefits. After receiving unemployment benefits for about one year, claimant became employed.

[4] Claimant Depo. at 12.

At the regular hearing, claimant admitted he was convicted of retail theft in Illinois 37 years earlier. He also acknowledged he injured his left shoulder in a motorcycle incident in October 2011 rather than in the spring of 2011. Claimant again insisted he never had back problems before his December 2011 work accident. He went to see Dr. Penner, his family doctor, beginning in June 2010 for pain in the left buttock, but did not disagree with the doctor's reports indicating complaints of pain at L5-S1. Claimant also acknowledged he declined Dr. Penner's recommendation of an MRI for financial reasons. Claimant indicated he was given a sheet with stretching exercises and prescribed Tylenol 3 with codeine.

On cross-examination, claimant confirmed he had been given two write-ups, known as memos of understanding, in August and November 2011. Claimant acknowledged the memos were directed specifically toward him. However, he averred the write-ups discussed at the deposition were directed toward the admissions department, placing everyone in the department on probation.

Claimant testified he had severe headaches, neck and back pain almost immediately after the accident. He later experienced pain in his legs. Claimant testified he reported the accident to Mr. Harris the following Monday, December 5. Claimant indicated respondent sent him for medical treatment at the Well Clinic at Walgreens on December 5. On the same day, claimant was also seen by Dr. Merrill A. Thomas at Via Christi. Dr. Thomas' note from that visit indicated claimant slipped on a piece of cardboard and fell, hitting his neck and head on the floor. Claimant complained to Dr. Thomas of lumbosacral soreness, tenderness in the upper thoracic and cervical spine, stiffness in the neck, but no leg pain. X-rays were taken of claimant's cervical, thoracic and lumbar spine. The doctor noted claimant had degenerative changes in the cervical spine with straightening of the cervical lordosis and no acute skeletal injury. No acute abnormality was identified in the thoracic spine. No acute abnormality was seen in the lumbar spine. However, there were some degenerative changes in the thoracolumbar level. The doctor's diagnoses were lumbar and cervical spine sprains.

In July 2013, claimant was involved in another motorcycle incident. He was driving slowly through a parking lot when a car backed out of a parking stall, bumped into claimant and knocked him over while on his motorcycle. Claimant again saw Dr. Thomas at Via Christi and complained of left wrist, left knee and low back discomfort. Dr. Thomas diagnosed claimant with left wrist, left knee and low back sprains. As claimant's injuries appeared mild, the doctor recommended observation, ibuprofen for pain and followup as needed. It was noted that claimant was already taking Lortab.

Claimant first saw Dr. Dobyns on December 13, 2011, and complained of headaches and persistent neck pain. The doctor's assessments were a head contusion with post-traumatic headache and cervical sprain. The doctor indicated that at their initial visit, claimant did not mention the October 2011 motorcycle incident or that he had made prior lumbosacral complaints to his family physician. According to Dr. Dobyns, claimant

never mentioned a lumbosacral injury to him. On June 6, 2013, claimant mentioned to Dr. Dobyns of having leg weakness. Dr. Dobyns testified claimant underwent a lumbar spine MRI ordered by Dr. Amitabh Goel. Dr. Dobyns had referred claimant for his cervical injury to Dr. Goel. Dr. Dobyns indicated that after he reviewed Dr. Goel's notes and the lumbar spine MRI report, he felt there was no structural explanation for claimant's leg weakness.

Dr. Dobyns ordered a cervical spine MRI that revealed no acute changes and preexisting degenerative changes with normal alignment of the spine. The MRI showed no fractures, spinal stenosis, nerve root stenosis or nerve root compression. An MRI of claimant's brain was essentially normal.

Dr. Dobyns testified:

> Q. Now, Doctor, I wanted to ask a question with respect to the claimant's injury. According to the Workers' Compensation Act and changes that went into effect in May of 2011, an injury is defined as any lesion or change in the physical structure of the body causing damage or harm thereto. Using that definition of [*sic*] your frame of reference, did Mr. Tripoli have an injury?
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> A. There was no injury that we could document with the sensitivity of present testing.[5]

However, on cross-examination, the following testimony was elicited from Dr. Dobyns:

> Q. Now, you were asked a question about the definition in the workers' compensation law of injury, and the first time you answered that question, you said something, and I didn't get it down exactly but something to the effect that [you] could not detect a change or lesion using the current tools available to us, or some words like that. What exactly did you say, and what did you mean by that?
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> A. Well, the -- we have certain tests available to us for evaluation of musculoskeletal injuries, and they can tell us a certain amount of information, but if we don't see something wrong, it doesn't mean that there's no reason for pain; it just means we could not --
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> Q. Detect it?
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> A. -- identify or detect a lesion. Like same way as if you get an x-ray of somebody's back who has a ruptured disk, the x-ray will be normal; but before we had an MRI, you had no way of knowing that except by examination. But now that we have MRIs, we have a more sensitive test that lets us identify this structural abnormality

[5] Dobyns Depo. at 14-15.

> that we couldn't before. So someday we may have a test that will show us a little bit more detail that will give us more information.
>
> Q. Just so that we're clear, you don't think Mr. Tripoli came in here, made this all up --
>
> A. No.
>
> Q. -- about getting hurt, do you?
>
> A. No.
>
> Q. And, in fact, you wouldn't have treated him over a year and a half, 11 different visits if that's what you thought, true?
>
> A. Correct.[6]

Dr. Dobyns opined, utilizing the *Guides*, claimant had a 5% whole body functional impairment for his cervical spine. When asked why he did not provide a functional impairment rating for claimant's low back, Dr. Dobyns explained:

> Because I, number one, never really addressed any complaints of lower back pain, and it wasn't until his last visit that he even mentioned that he was having trouble with his back. And it was only in hindsight that I looked at Dr. Goel's notes and saw that he was complaining of low back pain, it's not something he brought up with me ever. And so I did not feel that I had enough reason to give him disability on the basis of his back pain since he hadn't told me about it and since his MRI was unremarkable.[7]

Dr. Dobyns testified claimant would not need any future medical treatment other than palliative care, including pain medication. However, claimant would need periodic doctor appointments to monitor the toxicity of the medications. Dr. Dobyns provided claimant restrictions and gave a task loss opinion based upon the task loss analysis of vocational expert Steve Benjamin. The doctor indicated claimant's July 2013 motorcycle accident had no effect on his opinions.

As indicated above, Dr. Dobyns referred claimant for his cervical injury to Dr. Goel. Dr. Goel did not testify, but his notes from two appointments with claimant were placed in the record. The parties also questioned Dr. Dobyns concerning Dr. Goel's medical treatment of claimant. Claimant first saw Dr. Goel on April 27, 2012, and complained of neck and low back pain, headaches and pain radiating down the back of both legs to the

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[6] *Id.* at 30-32.

[7] *Id.* at 20-21.

knees. Dr. Goel's impressions were: (1) cervicalgia, cervical degenerative disk disease, cervical spondylosis, cervical sprain/strain, date of injury December 3, 2011; (2) symptomatic cervicogenic headaches; (3) clinical low back syndrome, lumbar degenerative disk disease, lumbar spondylosis with clinical lumbar sprain/strain, date of injury December 3, 2011, with clinically symptomatic facet arthrosis and (4) work-related injury, currently in litigation. Dr. Goel prescribed physical therapy, continued claimant's hydrocodone and anti-inflammatory and muscle relaxer medications and ordered a lumbar spine MRI. The MRI revealed mild lumbar spondylosis and a midline disc bulge at L5-S1, but no significant central canal or neuroforaminal narrowing.

Dr. Goel and/or his physician assistant saw claimant on June 13, 2012, and recommended bilateral L5-S1 facet injections and bilateral greater and lesser occipital nerve blocks. Dr. Dobyns testified claimant declined the injections, as there was a steroid scare at the time. He also testified that pain radiating down the legs could be an indication of non-verifiable radicular complaints. On cross-examination, Dr. Dobyns acknowledged claimant's lumbar spine MRI showed an annular bulge at L4-5, but indicated that was normal for someone over 50 years old, such as claimant. He agreed it was possible the bulge was caused by trauma, such as claimant's fall. However, he could not say it was probable claimant's mechanism of injury caused the annular disc bulge.

At the request of his counsel, claimant was evaluated by Dr. C. Reiff Brown on two occasions – January 5, 2012, and January 17, 2013. At the first appointment, Dr. Brown examined claimant's cervical and lumbar spine. He diagnosed claimant with cervical and lumbar sprains. The doctor found no evidence of radiculopathy or lower extremity weakness or atrophy.

When he evaluated claimant the second time, Dr. Brown had an opportunity to review claimant's cervical and lumbar spine MRIs. The doctor also reviewed additional medical records, including those of Drs. Dobyns, Goel, Penner and a Dr. Parman. The lumbar spine examination revealed flexion of 50 degrees, right and left flexion of 30 degrees and extension of 30 degrees. There was tenderness present over the lower three lumbar segments extending outward to the sacroiliacs and into the gluteosacral areas. No muscle spasm was noted in the lumbar or cervical paraspinals. Pulling discomfort was present at the end range in all directions of the lumbar spine. Dr. Brown indicated he used the active method to determine claimant's range of motion. He also testified claimant's tenderness and range of motion were logically located. Sciatic nerve stress tests, Patrick's and sacroiliac stress tests were negative. Waddell non-organic physical signs were negative. There was no apparent weakness, sensory deficit or radiculopathy in the lower extremities. The doctor noted a loss of deep tendon reflexes in the lower extremities.

Dr. Brown's January 17, 2013, report indicated claimant had mild degenerative disk disease in the cervical and lumbar areas that was symptomatic since the December 3, 2011, injury. Dr. Brown testified claimant sustained injuries to his lumbar spine, cervical spine and the back of his head as a result of the work accident. The January 17, 2013,

report states the work accident was the prevailing factor causing claimant's injuries, ongoing treatment and impairment.

Dr. Brown indicated claimant would have future flare-ups, for which he may need conservative treatment. Dr. Brown also testified he agreed with Dr. Dobyns that claimant would need future medication management and deferred to Dr. Dobyns regarding such treatment. Dr. Brown opined claimant was in DRE Cervicothoracic Category II and had a 5% whole body functional impairment for his cervical injury. He also opined claimant was in DRE Lumbosacral Category II and had a 5% whole body functional impairment for his lumbar injury. The doctor testified his impairment ratings were within the *Guides* and under the Combined Values Chart, the two 5% functional impairment ratings combined for 10%. He also testified claimant's entire 10% whole person functional impairment was the result of claimant's December 3, 2011, accident. Dr. Brown provided claimant with permanent restrictions and gave a task loss opinion.

On cross-examination, Dr. Brown was asked what lesion or change he was able to identify in claimant's physical structure. Dr. Brown testified a strain or sprain involves tearing of muscle or ligament fibers. When asked how he identified that, the doctor indicated claimant's fall would lead to that type of injury.

Dr. Brown was cross-examined at length by respondent's counsel. When respondent's counsel began asking the doctor a question about vertigo, the following exchange took place:

> Q. What causes vertigo?
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> A. I tell you, I think I'm not going to answer any more of your questions. I think you are chasing rabbits, you are at the bottom of your bucket and I'm tired of it. If you want to get more information out of me, let's get a date with the judge. And let the record show that I'm walking out.
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> MR. SCHAEFER: Doctor, thank you for your time. I apologize for your perceived inconvenience.
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> THE WITNESS: Oh, I'm sure. I'll waive signature.
>
> MR. SCHAEFER: I better put on the record that I question the admissibility of this deposition at this point in time as I was unable to complete my cross-examination.
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> MR. TORLINE: I think what he said was if you wanted to complete your cross-examination you should schedule it up with Judge Clark. And I think that's what he said. So I think --

> MR. SCHAEFER: I think the record shows that he got up and he walked out of the deposition, so that's really kind of preventing me from doing any more cross-examining.[8]

The ALJ found as follows with regard to Dr. Brown's testimony:

> Respondent's counsel did have the opportunity to cross-examine Dr. Brown to some extent. It should also be noted Dr. Brown's abrupt departure from his deposition denied Claimant's counsel any opportunity to conduct any redirect examination. While the Court does not feel Dr. Brown's testimony should be stricken in its entirety, the Court does consider Dr. Brown's termination of his deposition when considering the credibility to be given to his testimony.[9]

In light of the Board's findings below and for brevity's sake, the Board makes no findings of fact concerning claimant's permanent restrictions, task loss and wage loss.

PRINCIPLES OF LAW AND ANALYSIS

Admissibility of Dr. Brown's opinions

Respondent requests the Board to strike Dr. Brown's deposition transcript and exhibits thereto from the record. Claimant asserts he has no control over Dr. Brown and, therefore, his deposition transcript and exhibits thereto should not be excluded. Claimant also contends respondent could have asked the ALJ to order Dr. Brown to continue with the deposition and respondent was not prejudiced by Dr. Brown's actions. At oral argument, respondent indicated it did not know if it was prejudiced because it did not have an opportunity to complete Dr. Brown's cross-examination. Nor does respondent's brief indicate how it was prejudiced by Dr. Brown's actions.

Respondent's brief cites Georgia and Oregon cases in support of its position. *Soto*[10] is a criminal case. There, a witness refused to answer questions during direct and cross-examination at Soto's trial. The Georgia Supreme Court held the trial court would have been well advised to strike the witness' testimony, but neither party sought that remedy.

In *State v. Lea*,[11] another criminal case, Lea testified on direct examination that when he was interviewed by police, he felt trapped and felt he was not free to leave. When the prosecutor attempted to cross-examine Lea about being nervous when interviewed by

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[8] Brown Depo. at 64-65.

[9] ALJ Award at 9.

[10] *Soto v. State*, 285 Ga. 367, 677 S.E.2d 95 (2009).

[11] *State v. Lea*, 146 Or.App. 473, 934 P.2d 460 (1997).

police, Lea's counsel objected the prosecutor was going beyond the scope of direct examination. When the trial court overruled the objection, Lea invoked his Fifth Amendment right against self-incrimination and refused to answer any further questions when cross-examined. The Oregon Court of Appeals upheld the trial court's decision to strike Lea's direct testimony from the record.

The Board finds the above cases cited by respondent have little relevance to this situation. *Soto* and *State v. Lea* are criminal cases from different states and the facts differ substantially from the current case.

The Board will not strike Dr. Brown's opinions from the record. Respondent presented insufficient evidence that it was prejudiced by Dr. Brown's actions. Nor was there any showing Dr. Brown's actions rendered his opinions incomplete or not credible. Respondent did not raise as a defense that claimant had vertigo, a preexisting or personal condition, which led to his fall. The Board finds respondent was questioning Dr. Brown regarding vertigo, a medical condition having no relevance to the claim. Respondent cross-examined Dr. Brown on all relevant issues, including whether claimant had a change in his physical structure, whether his cervical and lumbar injuries resulted in a functional impairment, claimant's restrictions, his task loss and the need for future medical treatment.

K.S.A. 44-515(e) also supports the inclusion of Dr. Brown's opinions in the record. It states, in part:

> Any health care provider's opinion, whether the provider is a treating health care provider or is an examining health care provider, regarding a claimant's need for medical treatment, inability to work, prognosis, diagnosis and disability rating shall be considered and given appropriate weight by the trier of fact together with consideration of all other evidence.

K.S.A. 2011 Supp. 44-551(i)(1) grants ALJs with the authority to issue subpoenas and compel the attendance of witnesses. After Dr. Brown refused to complete his deposition and prior to the ALJ issuing his Award, respondent could have requested the ALJ to use his authority under K.S.A. 2011 Supp. 44-551(i)(1) to subpoena Dr. Brown to appear before the court, and take appropriate action if he failed to do so. Had respondent done so, this issue may have been resolved prior to the Award's issuance.

The Board wants to be clear: it does not condone Dr. Brown or any other witness in a workers compensation claim unilaterally refusing to complete a deposition.

Personal injury by accident

The Workers Compensation Act places the burden of proof upon the claimant to establish the right to an award of compensation and to prove the conditions on which that

right depends.[12] "'Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record unless a higher burden of proof is specifically required by this act."[13]

K.S.A. 2011 Supp. 44-508(f)(1) states:

> "Personal injury" and "injury" mean any lesion or change in the physical structure of the body, causing damage or harm thereto. Personal injury or injury may occur only by accident, repetitive trauma or occupational disease as those terms are defined.

At oral argument, respondent contended injuries such as sprains, strains and headaches that are not revealed by a diagnostic test are not injuries as defined by K.S.A. 2011 Supp. 44-508(f)(1). Respondent asserts no diagnostic test showed claimant had a change in the physical structure of his body and, therefore, claimant did not sustain an injury to his cervical or lumbar spine. The Board disagrees with respondent's analysis. Dr. Dobyns testified that prior to the MRI being invented, bulging discs could not be detected, as they do not show up on x-rays. The doctor then indicated some day more sensitive diagnostic tests may be developed that can show more physical abnormalities. Because a diagnostic test reveals no change in physical structure does not mean one has not taken place or there is no injury.

Drs. Dobyns and Brown opined claimant was in or had some components of DRE Cervicothoracic Category II and assigned claimant a 5% whole body functional impairment rating for his cervical spine. To be in DRE Cervicothoracic Category II, there must be a specific injury. Both physicians examined claimant and determined he had a specific injury. Their findings are uncontroverted.[14] Uncontradicted medical testimony unless shown to be improbable, unreasonable or untrustworthy, may not be disregarded.[15]

Claimant complained to Dr. Goel of neck and back pain. Claimant's lumbar MRI showed an annular bulge at L4-5. One of Dr. Goel's impressions was lumbar spondylosis with clinical lumbar sprain/strain, date of injury December 3, 2011. Dr. Brown opined claimant's lumbar injury was work related. Therefore, the Board concludes claimant

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[12] K.S.A. 2011 Supp. 44-501b(c).

[13] K.S.A. 2011 Supp. 44-508(h).

[14] The Board notes that even if it excluded Dr. Brown's opinions from the record, it would not alter the Board's finding that claimant sustained a personal injury by accident arising out of and in the course of his employment with respondent.

[15] *Anderson v. Kinsley Sand & Gravel, Inc.*, 221 Kan. 191, 558 P.2d 146 (1976).

sustained a lumbar injury by accident arising out of and in the course of his employment with respondent.

Respondent also casts aspersions upon claimant's credibility, because claimant's testimony on several matters varied from his deposition to the regular hearing. The Board has reviewed claimant's testimony in detail and does not share respondent's belief that claimant is not credible.

Nature and extent of claimant's disability

In his Award, the ALJ provided no explanation as to how or why he determined claimant had a 7% whole body functional impairment. The ALJ did not indicate if he was relying on a particular physician's opinion or was relying on a combination of Drs. Dobyns and Brown's opinions. Nor did the ALJ indicate claimant's functional impairment rating was based solely on his cervical spine injury or a combination of his cervical and lumbar spine injuries.

In *Tovar*,[16] the Kansas Court of Appeals indicated the existence, nature and extent of an injured worker's impairment is a question of fact. A fact finder is free to consider all of the evidence and decide for itself the percentage of disability. The numbers testified to by the physicians are not absolutely controlling.

The opinions of Drs. Dobyns and Brown that claimant had a 5% whole body functional impairment for the cervical spine are uncontroverted. The Board adopts those opinions with regard to claimant's cervical injury. The more difficult issue is whether claimant sustained a whole person functional impairment as a result of his lumbar injury.

Dr. Dobyns testified claimant never complained to him of low back pain. Therefore, the doctor did not assign claimant a functional impairment for his lumbar injury. The record shows claimant complained of a low back injury on December 5, 2011, to Dr. Thomas at Via Christi. Dr. Thomas diagnosed claimant with cervical and lumbar spine sprains. Claimant was treated by Dr. Goel in April 2012 for back pain and the doctor diagnosed claimant with a lumbar sprain/strain, date of injury December 3, 2011.

The Board gives equal credence to the opinions of Drs. Dobyns and Brown as to whether claimant sustained a functional impairment for his lumbar injury. Accordingly, the Board finds claimant has a 2.5% whole person functional impairment resulting from his work-related lumbar injury.

Claimant asserts the *Guides* provides that a fractional functional impairment rating should be rounded to the next number. If claimant's theory was adopted, a functional

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[16] *Tovar v. IBP, Inc.*, 15 Kan. App. 2d 782, 817 P.2d 212, *rev. denied* 249 Kan. 778 (1991).

impairment rating from 2.01% through 2.49% should be rounded down to the next lowest whole number, or 2%. A functional impairment rating of 2.5% through 2.99% should be rounded up to 3%. The Board would be obligated to round claimant's whole body functional impairment for his lumbar injury of 2.5% to 3%. Under the Combined Values Chart of the *Guides*, claimant's 5% and 3% whole person functional impairments combine for an 8% whole body functional impairment. Claimant then asserts he is entitled to a work disability, as K.S.A. 2011 Supp. 44-510e(a)(2)(C) provides:

> (C) An employee may be eligible to receive permanent partial general disability compensation in excess of the percentage of functional impairment ("work disability") if:
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> (i) The percentage of functional impairment determined to be caused solely by the injury exceeds 7½% to the body as a whole or the overall functional impairment is equal to or exceeds 10% to the body as a whole in cases where there is preexisting functional impairment; and
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> (ii) the employee sustained a post-injury wage loss, as defined in subsection (a)(2)(E) of K.S.A. 44-510e, and amendments thereto, of at least 10% which is directly attributable to the work injury and not to other causes or factors.
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> In such cases, the extent of work disability is determined by averaging together the percentage of post-injury task loss demonstrated by the employee to be caused by the injury and the percentage of post-injury wage loss demonstrated by the employee to be caused by the injury.

The Board disagrees with claimant's analysis for several reasons. First, the sections of the *Guides* placed into evidence do not indicate fractional functional impairment ratings should be rounded, up or down, to a whole number. The Combined Values Chart uses whole numbers, but does not indicate a functional impairment rating must be converted to a whole number. Second, K.S.A. 2011 Supp. 44-510e(a)(2)(C)(i) refers to a 7.5% functional impairment. That infers the Kansas Legislature does not require each and every functional impairment to be rounded to a whole number.

Third, a 7.5% functional impairment comports with K.S.A. 2011 Supp. 44-510e(a)(2)(B), which states:

> The extent of permanent partial general disability shall be the percentage of functional impairment the employee sustained on account of the injury as established by competent medical evidence and based on the fourth edition of the American medical association guides to the evaluation of permanent impairment, if the impairment is contained therein.

Drs. Dobyns and Brown testified they relied on the *Guides* in arriving at their functional impairment opinions. Thus, the 7.5% functional impairment the Board finds claimant

sustained as a result of his December 3, 2011, injury by accident is established by competent medical evidence and is based on the *Guides*.

Fourth, there is precedent for a functional impairment rating to be a fraction. In the following cases, the Board averaged the ratings of two or more physicians as a fraction:

•*MacMillan*,[17] two functional impairment opinions averaged as 15.5%;

•*Mejia*,[18] two functional impairment opinions averaged as 31.5%;

•*Jones*,[19] two functional impairment opinions averaged as 5.55% functional impairment to the right upper extremity and a 9.05% functional impairment to the left upper extremity; and

•*Madrigal*,[20] three functional impairment opinions averaged as 17.57% to the left upper extremity and 18.57% to the right upper extremity for claimant's bilateral upper extremity claim. In *Madrigal*, the Board noted, "Under these facts and circumstances, the Board finds this approach is reasonable and should therefore be affirmed."[21]

As indicated above, claimant sustained a 7.5% whole body functional impairment. Claimant is not entitled to a work disability as he did not prove his functional impairment exceeded 7.5%, as required by K.S.A. 2011 Supp. 44-510e(a)(2)(C)(i).

Future medical benefits

The Board adopts the ALJ's legal analysis on this issue and finds claimant is entitled to future medical benefits upon proper application to and approval by the Director of the Division of Workers Compensation. The Board acknowledges respondent's argument that Dr. Dobyns testified claimant may need palliative care in the future and that may is not the equivalent to more probably true than not claimant will need future medical treatment. However, when asked if he believed if future medical treatment would be necessary for

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[17] *MacMillan v. Department of Transportation, State of Kansas*, No. 184,813, 1998 WL 599396 (Kan. WCAB Aug. 31, 1998).

[18] *Mejia v. Cargill Meat Solutions Corp.*, No. 1,057,201, 2013 WL 2455701 (Kan. WCAB May 16, 2013).

[19] *Jones v. State of Kansas*, No. 217,708, 1998 WL 229889 (Kan. WCAB Apr. 30, 1998).

[20] *Madrigal v Schwan's Food Manufacturing, Inc.*, Nos. 1,020,288 & 1,026,193, 2007 WL 4661989 (Kan. WCAB Dec. 28, 2007).

[21] *Id.*

claimant, the doctor indicated claimant would need ongoing palliative care including pain medication. Dr. Dobyns did not use the term "may."

CONCLUSIONS

1. Dr. Brown's testimony and opinions and the exhibits to his deposition are part of the record.

2. Claimant sustained cervical and lumbar injuries by accident arising out of and in the course of his employment with respondent.

3. Claimant has a 7.5% whole person functional impairment and is not entitled to a work disability.

4. Claimant is entitled to future medical benefits upon proper application to and approval by the Director of the Division of Workers Compensation.

As required by the Workers Compensation Act, all five members of the Board have considered the evidence and issues presented in this appeal.[22] Accordingly, the findings and conclusions set forth above reflect the majority's decision and the signatures below attest that this decision is that of the majority.

AWARD

WHEREFORE, the Board modifies the February 14, 2014, Award entered by ALJ Jones by finding claimant is entitled to a 7.5% whole person functional impairment. Claimant is entitled to 31.13 weeks of permanent partial disability compensation at the rate of $555 per week, or $17,277.15, all of which is due and owing, less any amounts previously paid.

The Board adopts the remaining orders set forth in the Award to the extent they are not inconsistent with the above.

IT IS SO ORDERED.

[22] K.S.A. 2013 Supp. 44-555c(j).

Dated this ____ day of July, 2014.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

DISSENT

The undersigned Board Members respectfully disagree with the majority regarding the admissibility of the reports and testimony of Dr. Brown. Such evidence should be stricken from the record because both parties were, as a consequence of Dr. Brown's decision to walk out of his deposition, deprived of a reasonable opportunity to be heard and present evidence.

The constitutional requirements of due process are applicable to proceedings held before an administrative body acting in a quasi-judicial capacity.[23] The Kansas Supreme Court has recognized in numerous cases that the right to cross-examine witnesses testifying at administrative hearings of a quasi-judicial character is an important requirement of due process.[24] K.S.A. 2011 Supp. 44-523(a) provides that the parties shall be given a reasonable opportunity to be heard and to present evidence. There is no dispute that claimant and respondent/carrier were entitled to cross-examine witnesses whose testimony was offered by the opposing party.

It is not up to witnesses to decide whether, and to what extent, they are subject to cross-examination, nor do any witnesses have the right to determine what questions are relevant and material and which are not. Dr. Brown's termination of his deposition was improper because respondent was not allowed to complete cross-examination of

[23] *Neeley v. Board of Trustees, Policemen's & Firemen's Retirement System*, 205 Kan. 780, 784, 473 P.2d 72 (1970); *Saffer v. Star Construction, Inc.*, No. 1,030,669, 2009 WL 3191382 (Kan. WCAB Sept. 30, 2009); *Eubank v. State of Kansas*, No. 1,042,622, 2009 WL 2480261 (Kan. WCAB July 15, 2009).

[24] *Wulfkuhle v. Kansas Dept. of Revenue*, 234 Kan. 241, 671 P.2d 547 (1983).

Dr. Brown. The majority recognizes the impropriety of Dr. Brown's walking out of his deposition by stating the Board "does not condone Dr. Brown or any other witness in a workers compensation claim unilaterally refusing to complete a deposition."[25]

The majority suggests respondent, when faced with the refusal of Dr. Brown to complete his deposition, should have sought a subpoena from the ALJ to compel Dr. Brown's appearance in court. The fallacy of that notion is there is no requirement that a party must request permission of an ALJ to exercise its right to cross-examine witnesses. The parties already had that right – both pursuant to the Act and as a matter of procedural due process. Both parties should be allowed to exercise that right without seeking permission of the ALJ.

Moreover, as noted by the ALJ, claimant was deprived of his right to conduct redirect examination of Dr. Brown because of the latter's abrupt termination of his testimony.

Although the majority cites K.S.A. 44-515(e), it does not mention the subsection that immediately precedes it:

> Except as provided in this section, there shall be no disqualification or privilege preventing the furnishing of reports by or the testimony of any health care provider who actually makes an examination or treats an injured employee, prior to or after an injury.[26]

The reference to "the testimony of" does not only refer to direct examination, but, to make sense, must include cross-examination.

The majority emphasizes respondent did not show it was prejudiced by not being allowed to complete cross-examination. However, the right to conduct cross-examination of witnesses is an important right and the deprivation of that right, in and of itself, is sufficient to establish prejudice. Moreover, the full extent of any prejudice to respondent cannot be determined because respondent was not allowed to finish its questioning of the witness. What may have been established on further cross-examination or on redirect examination cannot be determined without speculation because the witness did not allow questioning to be completed.

Clearly, if Dr. Brown chooses to participate as an expert witness in a Kansas workers compensation claim and provide testimony at the request of a party to the claim,

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[25] Board Order at 10.

[26] K.S.A. 44-515(d).

he must submit to cross-examination regardless of whether or not he thinks counsel is "chasing rabbits."[27]

The majority erroneously assumes that a question by respondent about a reference in the medical records to vertigo supports the notion that the remaining cross-examination respondent intended to conduct was irrelevant. That conclusion is conjectural because respondent was prevented by the witness from asking further questions. Dr. Brown had no right to terminate further examination because he thought the line of questioning was irrelevant. The responsibility to make objections to relevancy belongs to the other attorney, not the witness. The authority to rule on such objections belongs to the finders of fact, not the witness.

The issue here is not the weight to be accorded Dr. Brown's opinions. Rather, the issue is whether Dr. Brown's testimony should be allowed into evidence when he unilaterally terminated the deposition without the completion of questioning by counsel. To allow the testimony of Dr. Brown into the record could have the effect of encouraging other witnesses – whether lay witnesses or experts – to improperly refuse to complete questioning in other claims.

The undersigned Board Members would strike from the record the entirety of Dr. Brown's deposition, including all of his reports.

BOARD MEMBER

BOARD MEMBER

c: Terry J. Torline, Attorney for Claimant
tjtorline@martinpringle.com; dltweedy@martinpringle.com

Matthew J. Schaefer, Attorney for Respondent and its Insurance Carrier
mschaefer@McDonaldTinker.com

Honorable Gary K. Jones, Administrative Law Judge

[27] Brown Depo. at 64.